THE

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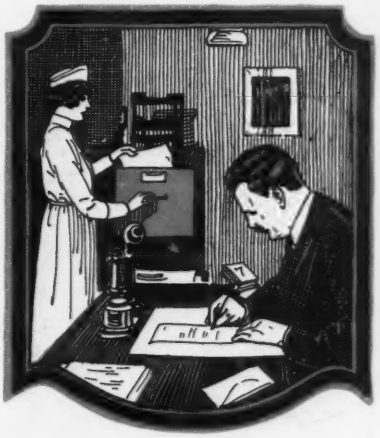

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The Operating Room and Its Equipment

By A. T. BAZIN, D.S.O., M.D., Montreal

THE Operating Room is an integral part of any and every hospital, general or special. It may be a makeshift or temporary arrangement in a small outpost hospital and in a very special hospital, or it may be an elaborate series of operating rooms and adjuncts as in a large general hospital.

To neither of these two extremes will I address myself in description. Native ingenuity will order the former, while the latter will have the benefit of architectural, engineering and technical advice.

But the vast majority of hospitals in Canada belong—as does the population—to the great middle class. These hospitals require a permanent operating room suite well equipped for practically all types of general and special surgery. Moreover they must "count the pennies" as indeed should even the largest and most heavily endowed hospital.

This middle class hospital may therefore shrink from the expense of technical and experienced advisors. But in avoiding this "Scylla" they may run foul of the "Charybdis" of high pressure salesmanship.

In Canada this dilemma can be entirely avoided by consulting the Hospital Service Department of the Canadian Medical Association.

The Montreal General Hospital has recently built a Private Patient Pavilion, including a suite of Operating Rooms. It has been in use sufficiently long to have demonstrated its good and bad points, and I will use it freely as the basis of my subsequent remarks—

1st—Location in Relation to the Other Parts of the Hospital

Convenience, and ease of transport of the patient are the essentials.

Vertical transportation by elevator meets these requirements.

Long lateral transportation should be avoided.

But care should be taken to ensure that the patient *in bed,* or even in bed with fracture frame and extension, should pass easily through all doors, corridors and elevators.

This is required because most patients now receive basal anæsthesia in their rooms and should be removed to the operating room without being awakened.

Single hung wide doors (45 inch) for the bedrooms are sufficient, but in corridors and in the operating room double hung doors (4 foot space) with check and closing springs (Yale) are more easy to control and take up less space in the swing.

The *height* of doors should also be sufficient to clear Balkan frames and/or fracture beds (7 feet).

2nd—Quiet

The operating room should be considered the sanctuary of the patient.

For the same reason as mentioned above, viz., basal anæsthesia in the bedroom or ward, there should be no noise until the patient is completely under the general anæsthetic—or throughout the operation if the anæsthetic be spinal or local.

Hence any apparatus and equipment to be used should be assembled in the operating room prior to the entrance of the patient.

Surgeons' and Nurses' Wash-up room should be separate but adjoining—as also should the sterilizing room.

Instrument cabinets should be outside the operating room altogether in order to avoid intrusion of those selecting instruments for any operation to follow.

3rd—Lighting

This subject was fully considered in a report to the Canadian Hospital Council and was published in Bulletin No. 3 issued by the Council.

Suffice it to repeat that:—

(a) Daylight from any source is not available at night, and is inadequate on dull or cloudy days. It is useless for transverse or lateral illumination and is too diffuse in concentration. In cold climates the large glass area is a danger to the patient unless a double installation is provided with special heating units.

An ordinary window is all that is required. Indeed, if the plans demand it, the operating room may be devoid of windows, be centrally placed, and ventilated by inlet and outlet flues under positive pressure control.

The windows should be fitted with slotted frames carrying an opaque roller blind in order that complete darkness may be obtained for endoscopic examinations and procedures.

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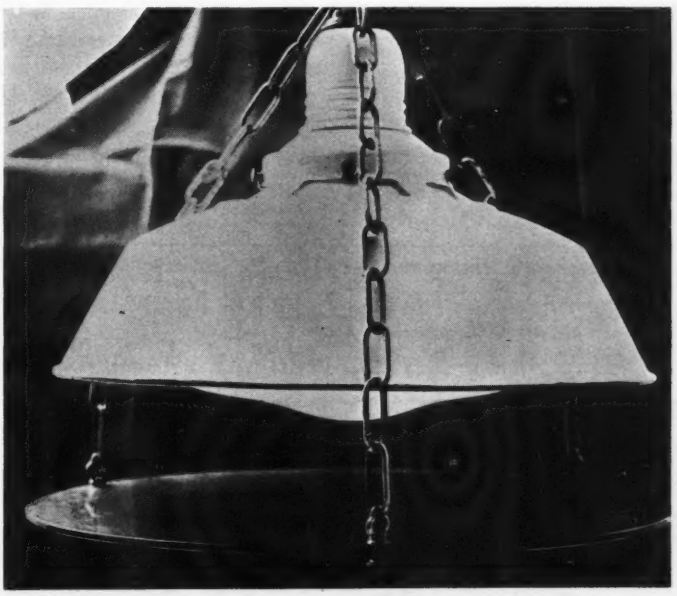


Figure 1.

300 watt bulb; white enamel reflector, 20 inch diameter; plate glass 21 inch diameter, suspended 3 inches below rim of reflector. Suspension by chain, 6¼ feet from floor.

The Operating Room and Its Equipment

(Continued from preceding page)

The "northern exposure" is a myth.

(b) Expensive and technically scientific illuminating ceiling installations, as also the so-called "shadowless" lights are quite unnecessary and a waste of good money. In my experience and observation none of them provide the lateral illumination claimed for them.

(c) The unit which we have used with satisfaction for years is one of our own design supplied at a cost of about $25.00 (Fig. 1).

(d) This is supplemented by one or perhaps two portable floor standard lights for lateral or "spot" illumination.

It is not required that these floor standards should be elaborate, with long over-reaching arms and complicated mechanism for adjustment. The top light is provided by the ceiling pendant, the floor standard is needed only for lateral or oblique illumination.

(e) General illumination of the room is obtained by two or four small ceiling fixtures operated by separate switches.

(f) For operative procedures under head mirror reflection a floor standard with bull's-eye lamp is an accessory requirement. In these instances also the nurse's instrument table should be lighted by a hooded floor standard lamp.

Before leaving this subject of lighting and to prove that the ideas enunciated are not untried theories I would like to say that in the new operating suite mentioned earlier in this article we have four operating rooms.

One of them, for architectural reasons, is fitted with large plate glass double windows for use of daylight.

In the majority of days the artificial light is a necessity. Moreover this window cannot be effectively screened and therefore this room is not available for endoscopic work or operations in which the head mirror or its equivalent is essential.

Another is fitted with the most expensive type of box ceiling installation. In spite of direct and forced flue ventilation from the enclosed box the surgeons complain of the heat (and we have not yet had summer experience with it). A floor standard is required for lateral illumination.

The other two rooms have our $25.00 ceiling light, a portable floor standard spot light and ordinary sash windows with the roller shades, and can be darkened at will.

For these latter rooms the surgeons have almost unanimously expressed preference.

4th—Colour Effects

As important as lighting is the avoidance of reflected glare upon the eyes of the surgeon. Therefore the floor and walls to above the level of the surgeon's eyes should be a neutral tint and of a non-reflecting surface. This will be dealt with more freely under the caption of Construction.

Likewise it is a decided advantage that the drapes upon the patient and the gowns of the operating team should be gray rather than white.

5th—Size, Arrangement, Construction

Size—An operating room cramped in size is conducive to errors in aseptic technique. There should be free space for an assistant nurse or an orderly to move about without danger of brushing against the sterile equipment or the pesonnel immediately engaged in the operation.

An optimum size is 17 x 20 feet. It matters not whether the operating table is end-on to the window or parallel thereto as the window is not a source of light (see Lighting).

No provision is here made for the accommodation of a class of students, but the floor space is adequate for two or three interested onlookers—properly gowned, capped, masked, and shod.

The ceiling clearance is immaterial. If the operating suite be situated on the top storey a ceiling clearance of eleven feet will make for cool comfort—a higher clearance is wasteful of construction costs—a lower clearance can be adequately ventilated (see Sterilizer Room).

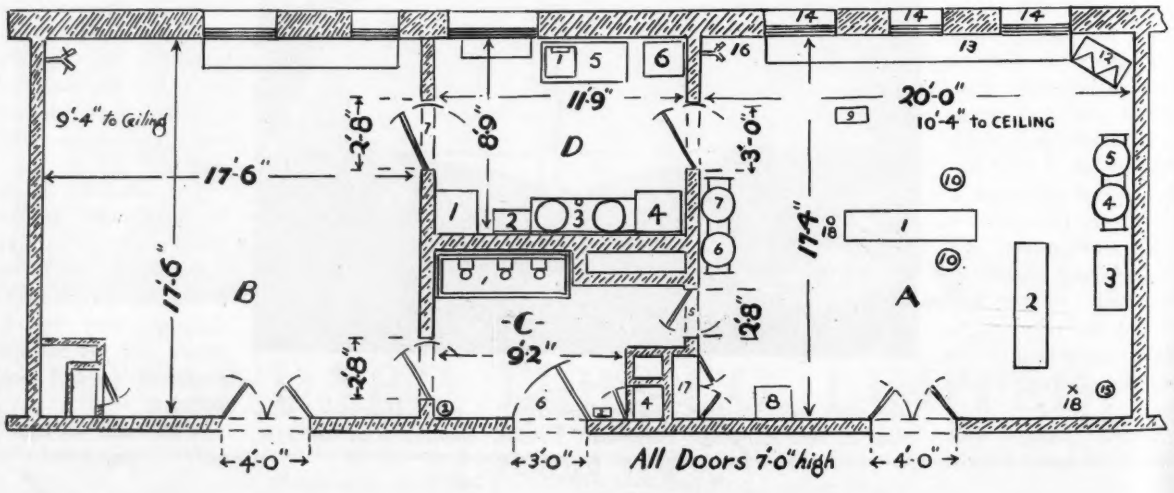
Arrangement.—Even small hospitals will find it both convenient and economical to provide a suite of two operating rooms with sterilizing room and wash-up room between, and connecting with both.

A diagram will illustrate better than will words, as below.

Key to Diagram—

Unit A. Operating Room equipped:

1. Operating table.



2. Nurse's Instrument and supply table.
3. Nurse's spare table.
4. & 5. Sterile drums for drapes, towels and nurses' gowns. etc.
6. & 7. Sterile drums for surgeons' gowns, etc. No. 7 small size for gloves.
8. Anaesthetists' service table. Gas machine not shown.
9. Table for material for skin preparation.
10.-10. Hand basins for surgeons.
12. Portable X-ray viewing box—double.
13. Radiators with gridded screen and top.
14. Windows—ordinary sash—with roller shade running in grooved box.
15. Portable spot light.
16. Double pet cock for suction. A portable electric set may be substituted.
17. Wall cabinet for storage of catgut jars, solutions, etc. Note that cabinets utilize space around pipe stacks and upright columns which otherwise would be wasted.
18. Stool—adjustable.
19. Irrigator stand.

Unit B. Operating Room unfurnished:

The operating Table in one room should be a pedestal table capable of assuming any of the positions desired for any operation.

The second Operating Table may well be of lighter construction, less flexible in change of posture and therefore much less costly. It will be found suitable for a large percentage of operations.

Unit C. Wash-up Room:

1. Wash-up sink—3 tap fixtures.
2. Alcohol receptacle.
3. Table for caps, masks and aprons.
4. Wall cabinet utilizing space about upright steel column.
5.-5. Doors to operating rooms—double swing—Richards-Wilcox hinges.
6. Door from corridor—Yale closer.

Unit D. Sterilizer Room:

1. Warming cabinet—Blankets, and flasks of sterile solutions.
2. Instrument sterilizer.
3. Hot and cold sterile water.
4. Utensil sterilizer.
5. Sink with draining board for instrument wash up.
6. Table.
7.-7. Double swing doors — Richards-Wilcox hinges. Louvered grids above doors.

Over the steam heated equipment (1-4) is a wide hood (not illustrated) contracting to a flue conduit leading direct to the vent house on roof containing the electrically driven fans. The steam and heat are thus carried off in a positive way. Moreover the grids over doors No. 7 will maintain a strong current of air passing from the operating rooms into and through the sterilizing room.

A cheaper but somewhat less efficient ventilation of the suite may be secured by installing in the outside wall an electrically driven fan forcing the inside air to the outside.

Construction of Operating Room

Floor.—Granolithic of mottled grey with brass strips forming squares of 10 inches. These brass strips, in the construction of the floor, should be "grounded" to a water or steam pipe.

The object of this is to permit of the employment of explosive anaesthetic mixtures, the static electricity being carried away by the simple arrangement of a light steel chain fastened at one end to the anaesthetic apparatus and dropped on the floor to contact the grounded brass strips.

The floor should be gently sloped to a trapped drain placed about the centre of the room.

Walls.—To seven feet from the floor, walls should be of a neutral tint of tile. Grey may be used but a light green we find most restful.

The tile surface should not be a highly reflecting gloss but a dull finish. It is kept clean just as easily as is the glossy surface.

Ceiling and upper walls. — Hard plaster—enamelled white. The more reflection from the ceiling the more adequate the general lighting of the room with small bulbs.

It goes without saying that the junction of floors, walls and ceiling should present no square corners nor ledges for lodgement of dirt or dust.

6th—Equipment of Operating Room

With few exceptions the equipment is adequately described in the key to diagram.

The tables and standards, in so far as is possible, are lacquered in a shade of green to match the tile walls, thus conferring a pleasing instead of a cold repellant appearance.

The portable X-ray viewing box is of our own design and was chosen instead of the usual inset wall box so that it might be rolled close to the operating surgeon if he desired to consult the X-ray at frequent intervals as in location of foreign body, etc. (Fig. 2, see next page).

Electrical wall plugs should be plentifully distributed about the room. The height from the floor should be about twelve inches. If lower they are liable to be wet and "shorted" in the washing down of the floor. If higher, the cables trip the unwary as they pass about the room.

Needless to say, all cables crossing the floor should be heavily rubber covered as fabric cables will become wet and "short."

In order to avoid a multiplicity of long cables crossing the floor we have devised and satisfactorily employ a gadget which consists of a block of wood 10 x 3½ x 4 inches with two or more sockets into which the plugs of the different electrical fixtures are inserted as desired. A heavy cable connects the sockets in the block to the wall plug.

Another device which has proven satisfactory is a "call" system consisting of a wooden block of similar size fitted with two pedals and connected by cable with special wall plug.

The block is placed beneath the charge nurse's table and the wires run to buzzers and annunciators in the orderly's station and nurses' work room.

The charge nurse can thus summon either a nurse or

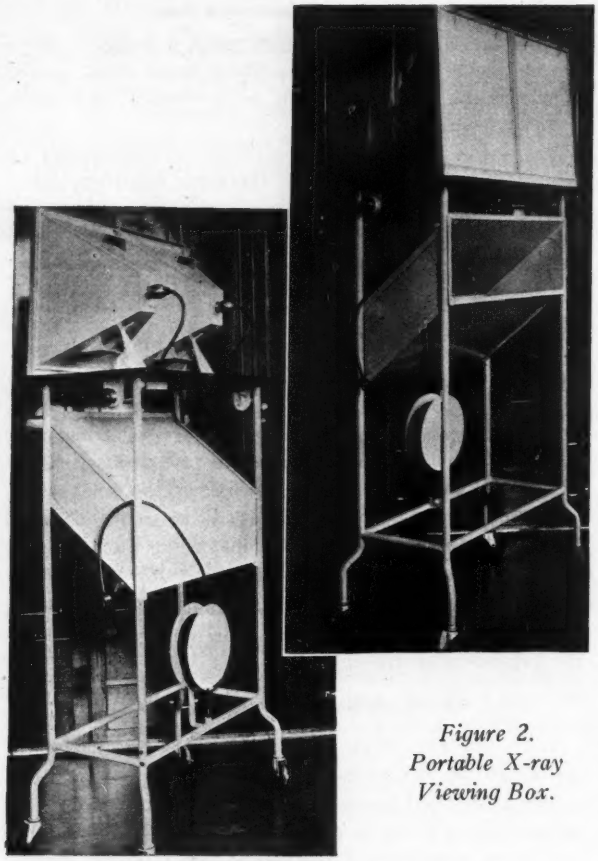


Figure 2.
Portable X-ray Viewing Box.

Pipe construction—rubber tired casters.
Standard Viewing boxes; faces tilted slightly backward.
Switch below viewing box for near light; similar switch on opposite side.
Inclined box shelf for films—sheet metal.
Reel to take up slack cable. Wires to bulbs run inside tubing frame.
Rear view also shown.
Height to top of viewing boxes—69½ inches.
Outside measurements of tube frame in mid portion—27 inches wide; 12½ inches deep.

orderly without changing position or interruption of her work. It also lessens the number of spare personnel in the operating suite.

7th—Surgeons' and Nurses' Wash-up Room

Lighting.—Artificial, or skylight if the room be on the top storey.

Ventilation.—Through the skylight—or grids above all doors.

Equipment.—One long deep sink is preferable to individual fixtures. The first cost is less and there is but one trap to keep clean. Dimensions of 6 feet long, 24 inches wide, 9 inches deep are adequate for three people to wash-up at the same time. A height of 36 inches from floor to top of rim prevents backache and also splashing of the person.

Avoid all kinds of automatic or mechanical tap mixers, also knee or foot controls. They are expensive to instal and to maintain and are constantly out of order.

A heavy fixture fastened to the back wall, with quick acting hot or cold taps operated by elbow blades, and centering on a large spray rose meets all requirements (Fig. 3.) As the wash up is begun the temperature and force of the water are adjusted by hand. At the conclusion of the wash up the water is shut off by pressure with the elbows. This satisfies the most strict aseptic technique.

Recesses for soap, or liquid soap fixtures, are placed on the back wall.

Chrome metal shelves running back to front on the sink may be fitted to hold brush and nail cleaning trays.

In the corners on each side of the door to corridor may be placed the alcohol for rinsing of hands and a table for caps, masks and aprons.

The surgeon enters from the corridor, adjusts his cap, mask and apron—scrubs up, goes through the alcohol and passes into the operating room ready for sterile gown and gloves.

Construction.—Floor granolithic of mottled grey; walls, tile to seven feet; ceiling and upper walls, hard plaster white enamel paint.

8th—The Sterilizing Room

Lighting.—Window.

Ventilation.—Forced—either by flue leading from top of hood over sterilizers to vent house fan on roof or by electrically driven fan set in wall above window.

By means of this positive ventilation the heat and steam from the sterilizers is prevented from entering the operating rooms.

Moreover, because of the grids over doors between sterilizing room and operating rooms a constant ventilation of the latter rooms is carried out.

Equipment.—Instrument sterilizer, utensil sterilizer, hot and cold sterile water. Cabinet (heated) for flasks of solution and for blankets. Sink and draining board for washing used instruments. Table.

Construction.—Floor, granolithic; walls, tile to seven feet; upper walls and ceiling, hard plaster—enamelled.

9th—Accessories

Across the corridor from the above described operating suite may be placed:

Nurses' work room.—For preparation of dressings and supplies, and for storing the same.

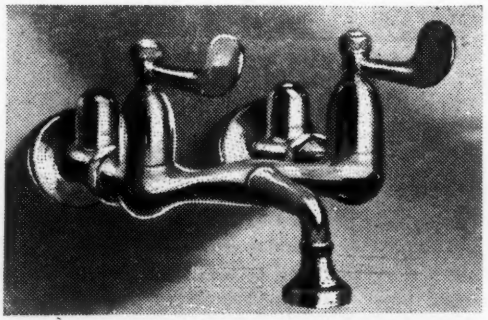


Figure 3.

(Continued on page 14)

Listerian Principles and the Development of Sterilizing Technique

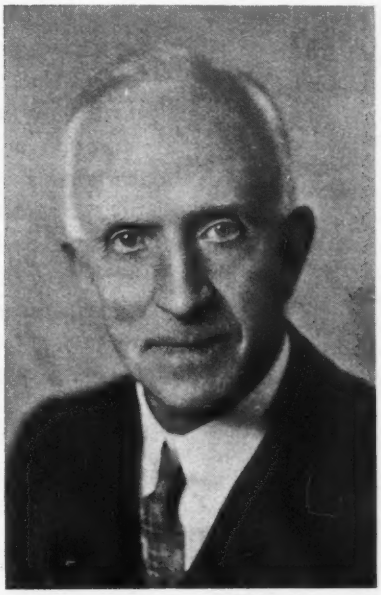
By W. HARGREAVES, Vancouver, B.C.

PART III.

IT was remarked in a previous part of this series that some contemporaries of Lister differed with him because they did not get the results which he obtained by his system. Comment was made that this was doubtless due to laxity in some detail or to errors in the preparation of the dressings. To-day, now that sterilizers have ben designed to so high a standard of excellence, and measures provided for full assurance of their effectiveness no contentions of like kind are ever proffered.

The modern Autoclave with its high degree of efficiency is not merely a monument of engineering science, it is characterized as an indispensible apparatus in the hospital's equipment.

The surgeon calls to his aid in his diagnosis all the knowledge gained in his academic training, the treatises of his profession; the experiences of his practice. He has at his command all the resources of laboratory evidence including X-Ray. He obtains a comprehensive clinical report, blood count, blood pressure, heart and kidney condition. After determining his own diagnosis he often consults for corroboration. When operation be indicated the surgeon knows every action and re-action right up to the point where the anaesthetised patient is on the operating table. Then—then he assumes, takes for granted, that his operating equipment and the dressings are in that sterile condition upon which the success of the operation will largely depend.



MR. W. HARGREAVES

The very fact, that the surgeon takes it for granted, puts the onus on the sterilizing department to prove all things with a certainty, an unquestionable exactitude equal at least to the other laboratory evidence.

With every loading of the sterilizer there is far more involved than the drums or bundles of dressings. Also, is there the welfare of the patient, the honour of the hospital, the reputation and character of the surgeon. It is reasonably imperative that where so much depends upon it, positive sterilization shall be fully assured and that the effectiveness of the apparatus shall justify itself in its operation. Such is a Listerian verity, the application of his principles and their execution by modern methods, which implies a knowledge of the methods as well as the principles.

Visualise the conditions within a loaded autoclave. Assume the bundles and the drums are properly prepared and in place. The door is closed. Perhaps 50%, or perhaps 70%, or maybe more of the sterilizing chamber is occupied by materials, the rest is atmosphere. It is now required that into every drum, into every bundle, through all the dressings within the drums or bundles and through every thread and fibre of those dressings, steam shall penetrate and permeate continuously for "Fifteen minutes at a maintained temperature of 248°F." (McKie & McCartney, ibid). As the sterilizer is the machine and steam the power, of equal importance is penetration as the motive of the operation. Penetration, penetration, continual penetration, the unceasing mobility of steam during the whole term of the sterilizing period.

This can only be obtained to full completion when the total elimination of the interspacial atmosphere has been effected. In a former issue the reason and the necessity of removing this atmosphere was explained in some detail. Suffice it to repeat here that air in the steam sterilizing chamber is not a sterilizing agent, rather to the contrary, it is a deterrent. Its elimination is imperative.

To accomplish this, there may be some slight difference in the operating of one autoclave as compared with another of different design. Designs of the several manufacturers vary in some detail of the mechanical arrangements. Sterilizers from the same factory are not all alike, the models having changed in the course of years of development, as a consequence the models of recent design vary most from those of earlier period, yet, with due recognition of these differences the experienced operator will have no difficulty in evacuating the atmosphere whether the autoclave has been in use several years or is just newly out of the factory.

The essentiality of steam penetration and its corollary air elimination are to be borne in mind during the loading of the bundles or drums into the sterilizer and throughout the period of the operation. The wrappers of the bundles should not be impervious and should be dry. Wet wrappers retard penetration. Drums should be packed and bundles made up not too tightly. Due attention is required to the placing of these within the chamber, at two places in particular. One is at the point of the steam inlet, not

to block or choke the acess of the steam; the other is to leave a space clear of the inner surface of the door when it is closed.

When the load is complete, or during the loading, steam may be generated in the outer chamber up to required pressure. It is to be noted that if the sterilizer be started from the cold, there will be air in the outer chamber and the generator. This should all be blown out through the pet-cock at the commencement or it will eventually pass into the inner chamber where it emphatically is not wanted.

The Purpose of the Vacuum

With the load correctly placed, the door fastened and all valves closed it is the common practise, with the majority of sterilizers now in use, to draw a vacuum. To obviate misunderstanding, the purpose of this is worthy of comment. Drawing a ten inch vacuum removes part, but only part of the atmosphere. The gauge showing ten inches of vacuum indicates that approximately one third of the air has been withdrawn. No matter how long that vacuum be held there will remain two thirds of the original atmosphere. Due to the elasticity of air it will have become attenuated but at no one place will there be a complete vacuum, the remaining two-thirds (approx) of normal air pressure within the chamber has yet to be driven out.

When the partial vacuum has been held for a short time, the steam is then turned into the inner chamber. In some later models, synchronizing with this, the ejection of the air will automatically begin. That is, it will, provided the ejector valve and all connections are in proper working order. In the older models, or such as have no ejector connections, the operation is slightly different. As soon as the steam is turned into the inner chamber, simultaneously with that movement, the drip valve at the bottom of the sterilizer should be opened. The movements in the latter instance should be as simultaneous as possible because if the drip valve be opened first, the vacuum will be nullified and its purpose rendered useless. On the other hand, if the steam be turned on first the pressure will simply recompress the attenuated atmosphere and possibly form localized air pockets within some parts of the bundles or drums. After the steam flows freely through the drip valve this may be partially closed, but not entirely. It should be slightly open during the whole sterilizing period.

Adverse Possibilities

The why and wherefore of the preliminary precautions and the visualisation of the inside of the autoclave may now be fittingly discussed.

Assume that the load and the sterilizers have been prepared up to the point where it is ready for the steam to be passed into the inner chamber. The steam pressure showing on the gauge of the outer chamber is customarily about 18-20 lbs. at this stage. Immediately the valve is turned that pressure of 20 lbs. per square inch is injected into the inner chamber. This stream of steam will act just like a stream of water, that is it will follow the line of least resistance. Every material object, bundle, drum or other article will be an obstacle to the course of the inflowing stream. Consequently the trend of the stream will be to surround the bundles, etc., if it cannot pass through them, filling the interspaces between the packages. As the pressure within the sterilizing chamber increases up to the customary maximum there will be a pressure surrounding each package equal to that shown on the gauge. Now, if the bundle has been wrongly prepared—wrapped in a wet wrapper, packed too tightly, or in any way difficult to penetrate—there will be an air pocket inside every such bundle: a pocket of air surrounded by a wall of steam at

Those of our readers who are acquainted with Mr. W. Hargreaves know of his interest in sterilizers and sterilization. In the first article of this series the brief but lucid portrayal of Lister and his work, reveals the spirit of admiration and loyalty which the writer has for the great surgeon and his beneficial discoveries. The subsequent treatise on some of the more obscure, and often problematical, features of sterilizing technique is drawn from a wide experience as well as from a comprehensive study of those principles rightly described by the writer as Listerian.

a pressure of 18-20 lbs. The possibility of such air pockets is greater if the vacuum technique has not been properly performed or if the ejector valve be in disorder, as the case may be in differing models referred to just previously.

Danger in Air Pockets

Every air pocket is a potential source of infection. Allowed to remain, the temperature therein will not rise to the required thermal death point within the period of a sterilizers normal operation.

Complete dispersion of any such danger zones must be ensured and should be as quickly as possible. Time is a criterion. Sterilizer operation is usually at full pressure for 30 minutes. Should it be that in the course of that 30 minutes it has taken 25 minutes to disperse any air pocket then has that particular zone not had the required 15 minutes at 248°F. (See diagram). Time, as quoted from eminent authorities, being an integral factor of the "thermal death point," such a bundle will not have had an entire exposure of either time or temperature. Hence it's potentiality for trouble.

The dispersal or breaking down of such air spaces and its complete elimination is effected by the open drip valve in some models and the ejector valve in others, as previously described. In either case the attendant should be sure that this is positively effected.

By the mental visualisation of the internal processes, other conditions than those just mentioned may be readily comprehended. The opening of the outlet valve not only ensures the dispersal of possible air pockets. It does more. By this means the steam is kept in continuous motion, consequently continuous penetration. Stationary or stagnant steam does not accomplish this, mobile steam does. Mobile steam is the sterilizing power at its maximum effectiveness.

For an even more comprehensive understanding of these movements it were well for the operator to note the

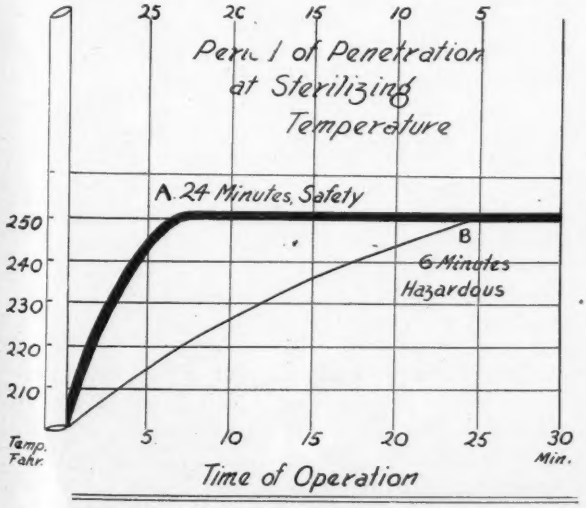
position of the steam inlet inside the sterilizing chamber. This is the source of pressure. Also observe the position of the outlet—here there is least pressure. The steam after entering by the inlet will naturally tend towards the point of least resistance, the outlet. The relative positions of these two points, indicating the trend of the steam, offers an explanation of internal temperature variations which seem to be an idiosyncracy of some sterilizers—if it may be said that sterilizers have idiosyncracies.

Condensation

The flow of water in much or less quantity from the drip valve is visible circumstantial indication that at some point within the sterilizer, condensation occurs during the whole sterlizing period. This is on the inner surface of the door. The door is the coolest part of the sterilizer by reason that—in the far greater majority—the whole body, excepting the door, of the inner chamber is surrounded by a steam jacket. The cooler the temperature of the sterilizing room and the greater will be the condensation inside the sterilizer. Cool draughts blowing on the sterilizer door will accentuate this even more. Condensation on the door indicates the necessity of leaving a space between the door and the load of dressings inside, firstly because where condensation occurs there is a lower temperature; secondly, dressings would absorb the water of condensation and retard penetration.

The reason for the general practise of operating sterilizers for 30 minutes is obviously one of safety. The truism, the complete destruction of all pathogenic bacteria and spores—which is the primary verity of Lister's Principles—is attainable with a reasonable margin to spare, provided the sterilizer is operating correctly according to rule.

The important part of the customary period of 30 minutes is the "15 minutes at 248°F., the thermal death point. This must be completely encompassed within the time of operation. Failure to accomplish this by reason of any defect in the sterilizer means that the dressings are not dependably sterilized. This feature may be better illustrated by a graph depicting (A) a sufficient, and (B) an insufficient period of penetration at the required standard sterilizing temperature.



A Heavy line shows penetration for full 20 minutes at sterilizing temperature 250°

B Light line shows penetration attained only in the last six minutes.

(A) The heavy line traces the rise of temperature after the steam enters the inner chamber. The location of temperature 248°F. being within the drum or bundle of dressings. Within 7-minutes the steam has penetrated each and all, and within the prescribed thirty minutes will have a good margin over the 15-minutes specified.

(B) The light line traces the rise of temperature where the interference (as previously discussed) retarded penetration. A temperature of 248°F. was not attained until the sterilizer had already been in operation for nearly 25 minutes; consequently here is an exposure for 6-7 minutes only, a hazardous period.

Observations have been made where 248°F. was not attained within a full hour at a pressure of 18-20 lbs. Instances of this kind can only occur where there is an inaccurate or defective condition such as has been described.

Obvious defects, as leaking valves, etc., have not been referred to as they are generally visible externally.

Instances of Defective Operation

The following are instances of insufficient penetration, with the causes discovered in each case:

Case 1.

Reported 40 minutes at 18 lbs. pressure failed to effect penetration. Three defects discovered. A. The gauge was in error, being several degrees inaccurate. B. No ejection valve, and scanty provision for drip escape. C. The main steam line was connected with a utensil sterilizer on floor below which robbed the autoclave of power.

Case 2.

Reported no penetration after several hours operation. An electric sterilizer with a defective heating element. Condensation, constant and heavy on inside was greater than steam generation from generator.

Case 3.

Reported impossible to get penetration at 20-lbs. pressure. Discovered defective ejector valve; prevented air dispersal and steam circulation; blocked evacuation of condensation.

Case 4.

Reported occasional indication of insufficient penetration. Large diameter sterilizer operated at night; windows open; cool night air blowing on sterilizer door; inordinate amount of condensation.

Case 5.

Reported safety valve blowing at 21-lbs. but no penetration through dressings. Safety valve was on outer jacket. Inlet was partially blocked and very little steam permeating dressings.

Case 6.

Reported insufficient penetration within a drum. No defects discovered in any part of sterilizer. Deduced by inference that drum either packed too tightly or shutters not fully open.

It is to be noted that in each case mentioned, the gauge was showing from 18 to 21 lbs., and the indicated temperature was 255 to 260°F., but in no instance was this temperature registering inside the particular drum or bundle in which the test was made.

Dietitians to Meet in Ottawa in April

A joint meeting of the Ontario and Quebec Dietetic Associations will be held in Ottawa, April 27, 1935. This one day Convention promises to be of exceptional interest. Such prominent men as Dr. I. M. Rabinowitch, Assistant Professor of Medicine, McGill University; Dr. E. W. McHenry, Department of Physiological Hygiene, University of Toronto; Dr. R. E. Wodehouse, Deputy Minister, Dep't. Pensions and National Health, Ottawa; and Dr. Joseph Kauffmann, Assistant Professor of Medicine, McGill University, will be on the programme.

Delightful plans for the social entertainment of the members have been made. Her Excellency, The Countess of Bessborough has graciously consented to receive the delegates. A motor ride through the City, including a visit to the Ottawa General Hospital, will be followed by Tea as guests of the Ottawa Civic Hospital. The Banquet, which will be held at the Chateau Laurier, will conclude a very profitable and pleasant day.

All Hospital executives, and members of the Medical and Nursing professions, are cordially invited to attend.

S. T. Martin Resigns Post at Regina General Hospital

Mr. Stanley T. Martin has resigned as assistant superintendent of the Regina General Hospital, and he is now enjoying a short holiday in Toronto.

Mr. Martin became first associated with the General Hospital at the time Dr. Hewitt was superintendent in the fall of 1929. At that time he was resident in the city as the representative of an eastern medical supply house.

His first work was as purchasing agent and he instituted a new system of purchasing supplies which is in effect today.

Mr. Martin enjoys the esteem of all those who are familiar with hospital work, and he was recently honoured by being named as a Fellow of the American College of Hospital Administrators.

Ontario Hospital Staff Changes Are Announced

As a result of the recent investigation at the Ontario Hospital at Hamilton, Dr. J. S. Stewart, superintendent of the Ontario Hospital, Toronto, has been appointed superintendent of the Hamilton institution, replacing Dr. J. J. Williams, who has been superannuated. Dr. Stewart, who is a native of Hamilton, was on the staff of the Ontario Hospital at Whitby from 1924 to 1930.

Dr. R. C. Montgomery, who is at present assistant superintendent at Hamilton, has been appointed superintendent of the Toronto Ontario Hospital, to succeed Dr. Stewart.

Bruce Carr, chief attendant at the Ontario Hospital, Hamilton, has been retired, and John Gilgot, supervising attendant of the Orillia Hospital, has been appointed to the position occupied by Mr. Carr.

National Conference of the Canadian Public Health Association

On Monday, Tuesday and Wednesday, June 3rd, 4th and 5th, the Canadian Public Health Association, in conjunction with the Ontario Health Officers' Association, the Canadian Tuberculosis Association and the Canadian Social Hygiene Council, will hold their Conference at the Royal York Hotel, Toronto.

PROGRAMME

Three joint sessions are being arranged. Among the visiting speakers expected are Surgeon General Cumming of the United States Public Health Service; Dr. E. L. Bishop, Commissioner of Health for the State of Tennessee and President of the American Public Health Association; Dr. C. L. Scamman, Director of the Division of Public Health of the Commonwealth Fund; and Dr. John A. Ferrell, of the International Health Division of the Rockefeller Foundation.

Nine Section meetings of the Canadian Public Health Associations: Each of the following Sections of the Canadian Public Health Association will provide one or more of the morning sessions: Public Health Engineering, Laboratory ,Epidemiology and Vital Statistics, Public Health Nursing, Industrial Hygiene, Mental and Social Hygiene.

Three special sessions of the Ontario Health Officers' Association will be held, including a series of demonstrations and the annual round-table dinner conference.

Clinical and formal sessions of the Canadian Tuberculosis Association are being planned for each morning.

Annual Meeting of the Canadian Social Hygiene Council.

Cancer Campaign is Launched on Radio

The Governor-General, the Countess of Bessborough, Premier Bennett, Rt. Hon. W. L. Mackenzie King and Sir George Perley joined, on March 1st, in launching a 66-day campaign to raise a national cancer relief fund to commemorate the 25th anniversary of King George's accession to the throne. The Prime Minister, who was ill, was not present, but his speech was read by Sir George, acting premier.

Over a coast-to-coast network the Earl of Bessborough asked that every household in the Dominion send $1 or more to Lady Bessborough, who has undertaken to receive and acknowledge all contributions which will be turned over for administration to a board of trustees. The campaign will close May 6, silver jubilee of His Majesty's accession.

Catholic Hospital Association to Meet in June

The Officers and Executive Board of the Catholic Hospital Association of the United States and Canada announce that on the invitation of the Very Reverend President and Board of Trustees of Creighton University, Omaha, Nebraska, the Twentieth Annual Convention is to be held at Creighton University, June 17th to 21st, 1935, under the patronage of His Excellency, The Most Reverend Joseph Francis Rummel, D.D., Bishop of Omaha.

Mr. E. L. Cockshutt Retires From Presidency of Brant San.

The retirement of Mr. E. L. Cockshutt as President of the Brant Sanatorium, Brantford, Ont., a position which he has so capably filled ever since its establishment, naturally brings to mind the great service he has rendered to this community in connection with this important office. Having been largely responsible for its inception, for 21 years he has watched closely over the Sanatorium, and has seen it develop from a very feeble beginning into the magnificent institution which it is to-day.

Mr. Cockshutt has placed the entire community under a debt of gratitude for his benevolent and unstinted zeal in its behalf, and he carries with him the good will not only of countless numbers who have benefited by the healing ministry of the Sanatorium, but also of hospital workers throughout the Dominion.

Another High Honour for Dr. E. W. Archibald

Still another high honour—the highest in the gift of his confreres of a sister Dominion—has been accorded to Dr. E. W. Archibald, surgeon-in-chief of the Royal Victoria Hospital, Montreal. On March 4 on the occasion of the opening of the new headquarters of the Royal College of Surgeons of Australia in Melbourne Dr. Archibald will be given an honorary fellowship in that body, the greatest distinction which the medical profession of Australia can confer.

There are very few members of Dr. Archibald's great profession whose pre-eminence in it have been more widely—and more deservedly—recognised than has his.

The Australian tribute to his professional eminence is but another evidence of what the world thinks of a great Montreal surgeon, a distinguished scholar and a very fine gentleman.

Soldiers' Wing Opened at Essondale

Announcement of the opening of the Soldiers' Wing at Essondale Mental Hospital, near New Westminster, B.C., has been received with general gratification at the Coast. Some ninety war veteran patients have been moved from other parts of the hospital and are now housed in the new wing, which has accommodation for 150.

The building is four stories in height. All of the ground floor is taken up by rooms for occupational therapy, and recreational facilities. There is a radio for the entertainment of the patients, and a large recreation room at one end of the building is equipped with billiard tables and other features designed to take the minds of the patients off their disabilities.

Each of the three upper floors is designed as one ward which has facilities for handling 50 patients. In the arrangement of the wards, the latest systems developed in the largest mental hospitals, have been adopted. Each bed is separated by partitions giving every patient what is practically a separate room.

The Operating Room and Its Equipment

(Continued from page 8)

This room should be furnished with a sink fixture and the one recommended is the combination sink and laundry tub.

Sterilizer room.—Autoclave for sterilizing in drums the gowns, drapes, towels, etc., for the operating room, and dressings, etc., for the whole hospital.

Bed Preparation Room.—This rom is most essential to the welfare of the patient. The patient arrives at the operating room in bed (vide ante) and at the conclusion of the operation is lifted from the operating table to the bed.

Throughout the operation the bed is in the Bed Preparation Room where it is firstly made up or rearranged and then an electric baker is placed under the bedclothes. The patient is thus returned to a bed in which the mattress and coverings are *soaked* with heat which the patient immediately absorbs.

This avoids the use of hot water bottles which are quite inadequate and not infrequently the cause of burns.

Surgeons' Dressing Room with lockers, showers, etc.

Store Room.—For accessory operating tables or chairs, spare tanks and apparatus for anaesthesia, etc.

Laboratory.—Small room fitted for the frozen section examination of biopsy material.

Office.—For supervising nurse—which may also contain the instrument cabinets.

A special room for anaesthesia is neither necessary nor desirable. An anaesthetic is never so smooth if started in one room and completed in another.

Dictation Room.—Facilities should be available for the prompt recording by the surgeon of the operative findings and procedures. A dictaphone may be used—or direct dictation to a stenographer.

Orderlies wash room.—For the washing down of tables, rubber pads and sheets, sorting out spoiled linen, etc. This room should be fitted with a commodious slop-sink.

If it is proposed to conduct urological examinations and procedures, as also fluoroscopic reduction of fractures and removal of foreign bodies a suite should be provided in conjunction with the Operating Room suite and under the same supervising staff.

This special suite would comprise a Urological Room with special equipment and table; a so-called Fracture Room with a desirable table, a sink with special plaster trap to ensure against blocking of drains; and between these two rooms an X-ray machine with control and loading rooms.

. . . . . .

Local conditions will of necessity require special modifications, but I trust I have outlined the essentials.

Record Librarians to Hold Annual Session in San Francisco

The Association of Record Librarians of North America will hold its seventh annual session in San Francisco, October 28 to November 1, inclusive.

Recent Canadian Hospital Statistics Are Interesting

The Dominion Bureau of Statistics has just issued its 1932 Census of Hospitals. The issuing of this report at an earlier date was prevented by the pressure of work during the past year and the difficulty in obtaining complete returns.

Of the 860 hospitals in operation in Canada, 589 are public, 214 private, 35 Dominion and 22 incurable, with a total bed capacity of 51,577 beds, excluding mental and incurable patients. The total collective days' stay, excluding infants born in hospital, was 12,048,923 days, and of infants born in hospital 905,139 days, making a total collective days' stay of 12,954,062 days. This means that on an average every man, woman and child in Canada spent 1.3 days in hospital during 1932. The average number of patients per day in hospital was 33,011, and the average length of stay of all patients was 19.3 days. During 1932 hospitals showed a bed occupancy of 64 per cent.

482 hospitals have X-ray facilities, 349 have clinical laboratories, 215 have well-equipped physical therapy departments, and 216 hospitals have out-patient departments, which treated 710,600 patients during the year.

The public hospitals reported a maintenance cost of 2.87 per day, while the private hospitals reported a cost of $3.22 per day. The estimated cost of the 860 hospitals is $37,995,778.

Copies of this Annual Report of the Hospitals in Canada may be obtained by writing to the Institutional Statistics Branch of the Dominion Bureau of Statistics, Ottawa.

Dates of International Hospital Congress are Changed

Information has been received that the International Hospital Congress, which was to have met in Rome early in May, has been postponed two weeks. This will bring the dates of the Congress at Rome to May 19th to the 26th. The study trip through Northern Italy, which has been arranged by the Italian Government, and which has attracted wide interest, will now begin on May 12th, at Milan. Otherwise the programme is as previously announced.

Edward M. Naylor, Now Manager

The Sarnia, Ontario, General Hospital board members have appointed Edward M. Naylor, Secretary-treasurer, to the new office of general manager, with complete charge of operation, in an effort to establish the hospital on a self-sustaining basis. Miss Lee, who has been superintendent for a number of years, will have charge of the nurses' training school and housekeeping.

A Close Shave

While awaiting an X-ray examination, Charles Anderson of New York, lay down to steal a few minutes nap in a private room in a hospital. Tired out, he slept well! In the next room a patient awaiting a head operation, also awaited a barber, but the tonsorial artist got his numbers mixed and when Mr. Anderson woke up, his head was smooth as a billiard ball.

D&G Kal-dermic is being widely adopted because it embodies the desirable features of *all* the materials traditionally associated with skin closure without their disadvantages.

It is non-capillary and, unlike silk, cannot act as a wick to draw infection inward.

It has the impermeable quality of horsehair, yet is much stronger.

Unlike silkworm gut it will not crack or split, is uniform throughout the strand, and adequate in length for all situations.

Its pliability, resistance to the action of tissue fluids, and freedom from irritative properties, make D&G Kal-dermic a decided improvement over other synthetic materials, and yet, in glass tubes, heat sterilized after closure, it costs no more than sutures in envelopes.

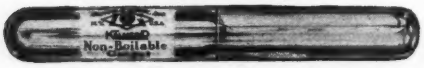
Prepared in sizes 8-0 (oooooooo) to 0 for skin suturing and 1 to 3 for tension work in several lengths and needle combinations. Literature sent upon request.

DAVIS & GECK, INC., 217 DUFFIELD STREET, BROOKLYN, NEW YORK

D&G Sutures

THEY ARE HEAT STERILIZED

Kalmerid Catgut



EMBODIES all the essentials of the perfect suture. Prepared in two varieties —Non-Boilable for those desiring the maximum of suture flexibility, and Boilable for those preferring to sterilize the exterior of tubes by boiling or autoclaving. Both varieties are heat sterilized.

THERMO-FLEX *(non-boilable)*

NO.		SUTURE LENGTH
1405	Plain Catgut	*approx.* 5′
1425	10-Day Chromic	" 5′
1445	20-Day Chromic	" 5′
1485	40-Day Chromic	" 5′

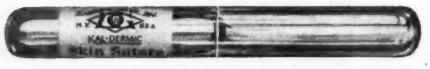
BOILABLE

1205	Plain Catgut	*approx.* 5′
1225	10-Day Chromic	" 5′
1245	20-Day Chromic	" 5′
1285	40-Day Chromic	" 5′

Sizes: 000..00..0..1..2..3..4
also 4-0 in non-boilable variety

Package of 12 tubes of a kind.....$3.60

Kal-dermic Skin Sutures



A NON-CAPILLARY, heat sterilized suture of unusual flexibility and strength. It is uniform in size, non-irritating, and of distinctive blue color. Boilable.

NO.		SUTURE LENGTH	DOZEN
550	Without Needle	120″	$3.60
954	With ½-Curved Needle	20″	3.00

Sizes: 000 (FINE) 00 (MEDIUM) 0 (COARSE)

852	Without Needle	40″	1.80

Sizes: 8-0..6-0..4-0..000..00..0

TENSION SUTURES

Identical to the above except in size.

NO.		SUTURE LENGTH	DOZEN
555	Without Needle	60″	$3.60
855	Without Needle	20″	1.80

Sizes: 1 (FINE) 2 (MEDIUM) 3 (COARSE)

In packages of 12 tubes of a kind and size

Kalmerid Kangaroo Tendons

GERMICIDAL, being impregnated with potassium-mercuric-iodide. Chromicized to resist absorption in fascia or in tendon for approximately thirty days. The Non-Boilable variety is extremely flexible. Tendon lengths vary from 12 to 20 inches.

NO.	
370	Non-Boilable
380	Boilable

Sizes: 0..2..4..6..8..16..24

Package of 12 tubes of a kind.....$3.60

Kangaroo Bands

KALMERID kangaroo tendons with a flattened area in the center, for the surgical treatment of fractures. Prepared with flattened areas in the following lengths 4½, 5½, and 6½ inches.

NO.	
378	Non-Boilable

Package of 12 tubes of a kind.....$4.80

Ribbon Gut

ABSORBABLE ribbon of animal intestinal tissue for nephrotomy wound closure by the Lowsley-Bishop technic, and with Atraumatic needles integrally affixed for hernioplasty, urethroplasty, and nephropexy. Length, 18 inches; width ⅝-inch. Boilable.

NO.		DOZEN
20	Plain Without Needle	$3.60
30	Chromic Without Needle	3.60
34	½-Circle, ⅞″ Taper Point Needle	4.20
35	½-Circle, 1⅜″ Taper Point Needle	4.20
38	½-Circle, 2″ Cutting Point Needle	4.20

In packages of 12 tubes of a kind

DISCOUNTS ON QUANTITIES

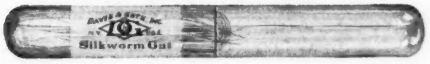
DAVIS & GECK, INC. ▾ 217 DUFFIELD ST. ▾ BROOKLYN, N. Y.

D&G Sutures are obtainable from responsible dealers everywhere; or direct, postpaid

THEY EMBODY EVERY SUTURE ESSENTIAL

D&G Sutures

Unabsorbable Sutures



NO.		SUTURE LENGTH	SIZES
350	Celluloid-Linen	60″	000, 00, 0
360	Horsehair	168″	00
390	White Silkworm Gut	84″	00, 0, 1
400	Black Silkworm Gut	84″	00, 0, 1
450	White Twisted Silk	60″	00 to 3
460	Black Twisted Silk	60″	00, 0, 2
480	White Braided Silk	60″	00, 0, 2, 4
490	Black Braided Silk	60″	00, 1, 4

BOILABLE

Package of 12 tubes of a kind $3.60

Short Length Sutures

FOR minor surgery and situations where full-length sutures are not required. Convenient and economical for use in the office or dispensary. Heat sterilized.

THERMO-FLEX *(non-boilable)*

NO.		SUTURE LENGTH	SIZES
702	Plain Kalmerid Catgut	20″	00 to 3
722	20-Day " "	20″	00 to 3
742	40-Day " "	20″	00 to 3

BOILABLE

802	Plain Kalmerid Catgut	20″	00 to 3
812	10-Day " "	20″	00 to 3
822	20-Day " "	20″	00 to 3
842	40-Day " "	20″	00 to 3
862	Horsehair	56″	00
872	White Silkworm Gut	28″	0
882	White Twisted Silk	20″	000, 0, 2
892	Umbilical Tape	24″	⅛″ wide

Package of 12 tubes of a kind $1.80

Kalmerid Umbilical Tape

SPECIALLY woven to provide maximum tensile strength and knot security. It is impregnated with potassium-mercuric-iodide, the ideal bactericide for the preparation of germicidal sutures and ligatures.

NO.		
92	In Jars—25 yards	each, $ .85
892	Tubes—24 inches	per dozen, 1.80

Emergency Kit Assortment

THREADED on half-curved eyed needles with cutting edges for skin, muscle, or tendon. Boilable.

NO.	
900	Assorted . . . Catgut, Silk, and Kal-dermic Skin Sutures, on Half-Curved Needles

Package of 12 tubes $3.00

Emergency Sutures

NO.		SUTURE LENGTH	SIZES
904	Plain Kalmerid Catgut	20″	00 to 3
914	10-Day " "	20″	00 to 3
924	20-Day " "	20″	00 to 3
964	Horsehair	56″	00
974	White Silkworm Gut	28″	0
984	White Twisted Silk	20″	000, 0, 2

Package of 12 tubes of a kind $3.00

Kalmerid Germicidal Tablets

THESE tablets were developed to meet demands from members of the profession acquainted with the value of potassium-mercuric-iodide, not only in the preparation of germicidal sutures, but as an antiseptic of wide applicability.

Each tablet contains 0.5 gram (7½ grains) potassium-mercuric-iodide

Bottle of 100 tablets $3.60

Other D&G Sutures

OVER a hundred suture-and-needle combinations for intestinal, thyroid, tonsil, eye, plastic, nerve, artery, obstetrical, circumcision, ureteral, and renal work. Complete list of sizes, lengths, needle combinations, etc. will be supplied on request.

DISCOUNTS ON QUANTITIES

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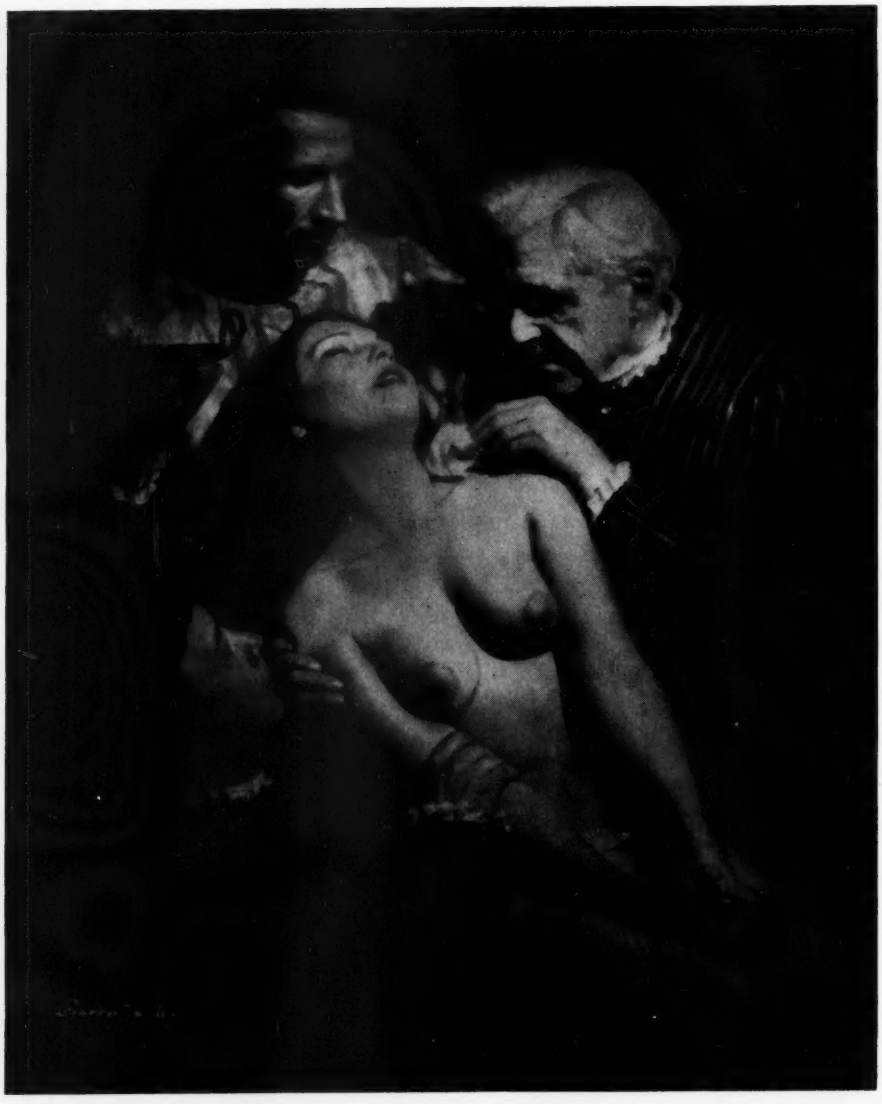
SUTURES IN ANCIENT SURGERY



FELIX WÜRTZ (*circa* 1500-1575) is considered by many to rank with the foremost surgeons of his day, and his *Practica* to be one of the most important and original works of the sixteenth century. It deals almost entirely with the treatment of injuries and criticizes such contemporary practices as needless probing and the indiscriminate use of sutures. Würtz, however, used sutures in harelip, tenorrhaphy, and when possible without tension, in certain wounds of the neck, face, and breast. Other wounds were, as a rule, sutured only in case of hanging flaps.

Women's Hospital Aids Association

Province of Ontario

President - - - - - - - - Mrs. O. W. Rhynas, Burlington, Ont.
Cor. Secretary - - Miss Mary Colter, 94 Nelson St., Brantford, Ont.
Treasurer - Mrs. G. W. Houston, 902 King St. East, Hamilton, Ont.

News of the Month

A CEREMONY rarely performed in Ontario was observed at the Chatham Public General Hospital when the probationers received their caps last month. Miss Priscilla Campbell, superintendent and principal of the training school, placed the cap upon the head of each probationer as a senior student nurse lighted the probationer's candle, in accordance with the procedure of the Florence Nightingale pledge.

Miss Campbell then read the following charge to the class, which was written by Mrs. O. W. Rhynas, and which has been accepted for use in various training schools:

This cap is reverently placed upon your brow. It is a symbol of your entrance into the sacred walls of this hospital—(your Alma Mater)— to accept the training and moulding of your mind and body to best fit you for the profession you have chosen, that of committing yourself and your best knowledge to the care of the sick and suffering. This cap is a symbol of trust, of purity and of sacred service; honour it and keep it pure as God's new snow. Within its folds are treasures very dearly bought by those who walked the halls of pain from years ago until now.

You will possess these treasures just as largely as you give yourself to the study and care of the sick. You will enjoy the beauty of this service as largely as you enter into it in spirit, working always to attain to the best, keeping firm to duty and being kind. This day you stand at the gateway, lifting the latch as it were to entrance into the preparation of a sacred calling— with the privilege of using the richness of knowledge and training at hand and application of your best skill and womanhood to fit you for the services and emergencies of the nursing profession.

The prize for which you yearn will be won only by your days being replete in worthy application, the laurels won will be through going the second mile—in service, application, tact, grace and dignity—with high purpose and courage ever your guide—abstinance from any habit or act which will not help you carry the seal and sacredness of this high calling to its best heights.

The road is steep and can never be climbed successfully through selfishness or carelessness of either mind or body. The road to high attainment was ever hardly won, never by pleasures, self indulgence or basking in life's sun. Habit and imitation are the source of all working, and all apprenticeship, of all practice, and all learning, in this world.

It was Bryron who said, "My very chains and I grew friends, so much a long communion tends to make us what we are; even I regain'd my freedom with a sigh." That magnificent harness of routine which enables us to mould ourselves into the manifold duties, obstacles and requirements—with a sublime dignity and efficiency is a priceless master if we but bend to and cheerfully accept the lessons we receive in this path of obedience.

Never ever fear to bring the sublimest motive to the smallest duty and the most infinite comfort to the smallest trouble. In so doing you will find reward at every turning of the road .

* * *

INGERSOLL.—With cheery grate fires and softly glowing lamps, the nurses' home, Thames street south, provided a beautiful setting for the crowds that attended the formal opening there in February. The affair was arranged under the auspices of the Women's Auxilliary to the Alexandra Hospital Trust and was an outstanding success.

The furnishings were all very dainty and were in colour schemes of rose, blue, mauve and yellow. Attractive new curtains harmonizing with the newly-painted furniture and pretty chintz-covered chairs, followed out the colour harmony.

A well equipped kitchen and laundry are among the facilities of the residence.

* * *

NIAGARA FALLS.—The Women's Auxiliary of the General Hospital report a splendid year's work, with many social activities which have added funds to the treasury. Among the most successful functions was a travelling bridge, after which guests returned to the nurses' home for tea.

The deaths of Mrs. P. A. Skinner and Mrs. W. R. Price, remove two of the oldest and most valuable members on the board. Their splendid work and results will live always.

THE Canadian Hospital

Published in the interests of Hospital Executives

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OF EVERY MONTH BY

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Civic Hospitals and Their Administration

THE present vacancy in the superintendency of a large civic public hospital again draws attention to the administrative difficulties which are very liable to beset the administrator of a civic institution. We understand that the assistant superintendent of this hospital did not accept an invitation to have his name considered for the superintendency, and has since severed his connection with the hospital largely because he could not be assured of protection from uncalled for and unjust public criticism. This very factor makes many competent administrators hesitate to apply for superintendencies in some civic institutions.

There has been in recent years a definite tendency towards municipal ownership, and theoretically there would be much justification for the principle that the responsibility of caring for the sick should be placed upon the community as a whole rather than upon a few generous members of that community. We have ample evidence also that municipal hospitals can be operated efficiently and can command the services of some of the finest hospital executives in the country. At the same time there would seem to be in a number of our civic institutions an unusual amount of discontent and unrest, a definite disturbance of public confidence and an undermining of the morale of the personnel.

Referring to civic hospitals in general and to none in particular, it would appear that these difficulties are prone to develop where public hospitals are under municipal management. It is generally recognized in the hospital field that the administration of a large municipal hospital meets with difficulties not encountered in anything like the same degree in hospitals operated by voluntary boards of management. There is a definite tendency, more marked in times like these than at other times, for the difficulties of the civic hospital to become a public issue. The alleged shortcomings of such a hospital are given the fullest publicity and sooner or later, as has happened in several Canadian cities, the hospital is thrust into the political arena.

The administration of a civic hospital is particularly difficult. It is hard to build up a smooth, co-ordinated, well disciplined organization for all too often outside interference nullifies the directing hand of the administrator or the dismissal of an unsatisfactory employee is held up by some civic official or made a front page controversy. The employment of unqualified individuals may be "requested" by members of the city council. The employment of expert help may be prevented by a silly adherence to a vote-getting policy of employing only local personnel. Salaries of executive heads may be slashed so deeply in order to satisfy a section of the public that the right people are not interested in applying for positions or have their morale sapped if already engaged. Medical men of doubtful training for special procedures may "demand" the right to do major surgery or other delicate work and jeopardize human life because they are taxpayers. Above all the administrator in some civic hospitals is denied the advice and council of a well-informed sympathetic Board of Trustees.

In some hospitals the trustees are elected by the ratepayers—an arrangement which means constant change of of policy and which often means the retirement of a trustee just when he or she is beginning to get an inkling of the real and peculiar problems associated with hospital management. The trustee may not have any real sympathy for the hospital itself; he may have succeeded in gaining his election on the avowal of "cleaning up the hospital mess," or he may look upon the trusteeship as some regard membership on the Board of Education—a stepping stone to other civic houours.

Sometimes, and this is the most deplorable situation, there may be no Board of Trustees as such at all, either elected or appointed, and the management is directly under a Committee of the City Council, an arrangement which means no continuity of membership at all; which means a Board with very limited actual knowledge of hospital management, no matter how well intentioned its members, and which cannot help but draw the hospital into the political arena with all its public and press criticisms and censure—a state which may be the breath of life to the individual gladiators but which is absolutely fatal to the hospital in its efforts to hold the public confidence. More than one fine and noble institution has been wrecked to satisfy the political ambitions of its "friends."

It should be emphasized that not all civic institutions have so suffered. Several of the best hospitals in the country are municipally owned and have been fortunate enough to obtain the services of outstanding citizens as trustees. Nevertheless they have avoided these pitfalls only by most careful planning and their efforts should be an inspiration to others. There must be established a definite "hands off" policy. The by-laws should be so revised that there can be appointed a hospital board of public spirited citizens, who will hold office for a number of years, preferably five years, and who will have the final say in any matter relating to the hospital except approval of the hospital budget, which would have to be obtained from the City Council, to which body the Board

would be subject. Even in financial matters individual items on the budget should be referrable to the Board only. This Board should handle all matters of appointment or dismissal and patronage should be absolutely eliminated. The Board should be appointed by the Council and not publicly elected. Regulations should be drawn up clearly defining the responsibilities of all individuals or groups attached to the hospital and the approach to various members of the administration or the Board should be through clearly defined channels. There is no reason why our civic hospitals should not flourish even better than the voluntary non-profit type of public hospital, the principal of civic ownership is sound, but not until the management of the civic hospital is completely removed from the field of civic politics can its full efficiency be attained.

Hospitals Are Deeply Interested in Federal Social Legislation

WITHIN the past few weeks Parliament has approved The Employment and Social Insurance Act. This is of interest to our hospitals in Canada because of both the unemployment insurance clauses and the section relating to health insurance. The details of the operation of unemployment insurance are to be left to a large extent to the commission which will direct the workings of this enactment. Apparently to that body will be entrusted the amplification of the many details which must arise as time goes on. It is unlikely that hospitals will be very much affected by this legislation. Professional nurses and nurses-in-training are to be exempt and whether or not the office staff and various service department employees are to be included or not will be determined at a later time by the commission.

As a general rule, hospital employees are subject to very few periods of unemployment. Very few, if any, groups of employees have steadier employment than that provided by hospitals. Therefore, from the viewpoint of the employee in the hospital, there is not very much need for this provision. If it is found necessary to cover certain groups of hospital employees, it is not anticipated that the cost to the hospital will be very heavy due to the limitation of the group.

The section of the act which deals with health insurance is also of interest to hospitals because it paves the way for federal legislation on health insurance, which development naturally would very definitely affect our public hospitals. It would appear from the wording of the section, however, that the present intention would be to collect and study data relating to the provision of health insurance, rather than to proceed at once with the establishment of any such plan on a national basis. Apparently the same commission which is directing the unemployment insurance plan will be empowered to develop the studies of health insurance, and to this end an advisory committee of individuals conversant with various aspects of the subject will be called upon by this commission for advice and counsel. We would anticipate that before definite action would be taken ample opportunity would be given for the hospitals to study proposals and present views to the commission.

(Continued on next page)

The portion of the act covering health insurance (Part IV. of the Employment and Social Insurance Act) is as follows:

The duties and powers of the Commission under this Part of this Act shall be exercised, so far as may be found practicable and expedient, in co-operation with any department or departments of the Government of Canada, with the Dominion Council of Health, with any province or any number of provinces collectively, or with any municipality or any number of municipalities collectively, or with associations or corporations.

It shall be the duty of the Commission

(a) to assemble reports, publications, information and data concerning any scheme or plan, whether a state, community or other scheme or plan for any group or class of persons, and whether in operation or proposed, in Canada or elsewhere, of providing, on a collective or on a co-operative basis by means of insurance or otherwise, for
   (I) medical, dental and surgical care, including medicines, drugs, appliances, or hospitalization or
   (II) compensation for loss of earnings arising out of ill-health, accident or disease;
(b) to analyze and make available to any province, municipality, corporation or group of persons desiring to use the information so assembled for the purpose of providing such benefits or any of them; and
(c) as far as may be found practicable so to do on request by any province, municipality, corporation or group of persons, to examine and report on any such scheme or plan proposed to be put into effect or in effect at the date of such request, and to afford technical and professional guidance in regard to the establishing, working or reorganization of the scheme or plan.

The Commission may from time to time submit to the Governor in Council proposals for co-operation by the Dominion in providing any of the benefits enumerated in paragraph (a) of the next preceding section of this Act for such action as the Governor in Council is authorized to take, and may undertake special investigations in regard thereto, subject to approval of the Governor in Council concerning the scope and nature of each such investigation.

What Are You Doing to Promote Hospital Day?

THIS year it is anticipated that more hospitals than ever will celebrate National Hospital Day on May 12th, for in so doing they not only honour Florence Nightingale, but also perpetuate the spirit of the founder, the late Matthew O. Foley.

Hospital Day has proven a most effective means of creating hospital publicity, and the National Hospital Day Committee of the American Hospital Association has recently issued a pamphlet with 35 excellent suggestions for programmes which will focus a great deal of public attention on hospitals. Many features likely to interest the public in their hospitals are included in this list of suggestions, such as posters displayed in show windows and public elevators; displays in downtown store windows, invitations to visit the hospital printed on milk bottle caps; Hospital Day trailers at local theatres, "open house' for inspection of various hospital facilities, and a "reunion" of all babies born in the hospital. Photographs are always in demand for publicity work and pictures of twins, triplets, or of patients who have had interesting cures have an emotional appeal to the public.

The type of programme to be arranged by your hospital should be left to a local committee familiar with the community needs and many valuable suggestions for a successful celebration in your hospital may be obtained by writing to the National Hospital Day Committee of the American Hospital Association, 18 East Division Street, Chicago.

Correspondence

The Editor,
"The Canadian Hospital,"
Toronto, Ontario.
Dear Sir:

May I ask for space in your journal to correct an erroneous statement which appeared in an article under my name which was published in the February number of "The Canadian Hospital" under the title "British Columbia's Response to the Challenge of the Nursing Survey."

That the material presented was a stenographic report of a Round Table discussion (not the copy of a written paper) should be borne in mind (as some details such as references, etc., were undoubtedly omitted); but this fact has no direct bearing on the correction which I wish to make. The responsibility for the mis-statement is entirely mine.

Speaking of the closing of nursing schools in British Columbia and the reduction in the number of students in this province, I quoted from the British Columbia Hospital Statistical Sheets of 1930 and 1933, which showed a reduction in the non-graduate nurse, or student, group of 162, and a corresponding increase of 165 in the number of graduates employed. I then quoted from an article which appeared in the September 1934 issue of "The Canadian Nurse" which gave the figures of the total number of nurses registering in Canada during the same years (1930 to 1933) and also the number of "first registrants" during the same years. The number of "first registrants" (which would indicate approximately the number of new graduates) was in 1933 lower by 177 than the number of "first registrants" in 1930.

In my discussion a comparison was made between the two figures 162 and 177, although they are not comparable —162 referring to the decrease in the whole number of students in training in British Columbia (first, second and third year students) while 177 referred to the decrease in the number of graduates during the same period for all Canada. Although the figures were correctly quoted, as

the comparison made was not in order the inference drawn was necessarily false.

My attention was some time later drawn to the comparison I had made and realizing my error, I tried to correct the statement before the report should be published; unfortunately I was too late to do this. In a recently published Annual Report of one of the British Columbia hospitals exception was taken to the statement and the comparison I had made. Since the question of reduction in student personnel is one of considerable importance, and since the figures I had given may be noted and cause comment elsewhere, I wish very much to have an opportunity of correcting the mis-statement. I am sure I need not say that the mistake was unintentional and that I regret the carelessness which led to it.

Yours very sincerely,

MABEL F. GRAY.

President, Graduate Nurses' Association of British Columbia.

Death of Sister St. Aldegonde at Sudbury

Sister St. Aldegonde, Superior of St. Joseph's Hospital, Sudbury, for the past two years, died on January 24th, at the hospital.

Sr. St. Aldegonde was born at Maniwaki, P.Q., the 16th of May, 1878, and followed a course of studies in the Convents of Maniwaki and Aylmer.

At the age of 16 she entered the Novitiate of the Grey Nuns of the Cross at Ottawa, completed her studies at the Normal School and taught in the Capital for 20 years, and at Bouchette, Ville Marie and Sudbury for 4 years.

At the General Hospital, Ottawa, Sister followed a four years' preparatory course for the Toronto College of Pharmacy, where she received the degree of Bachelor of Science in Pharmacy. Sister was then appointed pharmacist at the General Hospital.

In 1913 was named principal of the Separate School in Sudbury, and in 1927 was named Secretary and Chief pharmacist of St. Joseph's Hospital.

In 1930, Sister St. Aldegonde was appointed Superior of St. Charles' Home and the St. Vincent Annex.

Three years later, the Sister returned to Sudbury as Superior of St. Joseph's Hospital.

Imposing obsequies were held at the Mother House of the Order, at Ottawa. Rev. O. Voyer, O.M.I. Chaplain of the Community, officiated, assisted by Rev. L. C. Raymond of Wrightville, P.Q.

Reverend G. Verreault, O.M.I. of the University of Ottawa, and Reverend R. Bergeron, Chaplain of St. Charles' Home, said Mass at side altars.

His Excellency, Archbishop G. Forbes of Ottawa, presided at the Libera.

Present also in the Sanctuary, were Rev. C. Glaude, Chaplain of Ottawa General Hospital, and Rev. R. Martin, Secretary of the Archbishop.

The Community of the Grey Nuns has sustained a serious loss in the death of Sister St. Aldegonde, who filled so efficiently the different responsible positions entrusted to her, and on whom the Community counted largely for the future.

News of Hospitals and Staffs

A Condensed Monthly Summary of Hospital Activities, and Personal News of Hospital Workers

BALTIMORE, R.I.—Miss Elsie M. Lawler, native of Whitby, former assistant lady superintendent of Toronto General Hospital, and for the last 25 years principal of the school of nursing and superintendent of nurses at Johns Hopkins Hospital, Baltimore, has been granted an honorary degree of master of arts by the Johns Hopkins University. Conferring of the degree took place on February 22, at the 53rd anniversary of the founding of the university.

* * *

CHATHAM, ONT.—Trustees of the Public General Hospital have passed a by-law authorizing the borrowing of $20,000 to complete the upper storey of the new wing of the hospital. The project will be undertaken in the near future. Fifteen new rooms for patients and a new operating room will be provided.

* * *

DIGBY, N.S.—The Digby General Hospital has installed new X-ray equipment. Dr. W. R. Dickie, of Digby has been appointed radiologist, and before assuming his duties, spent considerable time in Montreal making a study of X-ray work in the hospitals of that city.

* * *

HAFFORD, SASK.—Dr. Arthur O. Rose, formerly of Winnipeg, and for the last 12 years in charge of the United Church Hospital at Hafford, Saskatchewan, has purchased the institution, which he will operate in future as a private enterprise.

Dr. Rose is a graduate of Wesley College in arts and theology and for two years served as a Y.M.C.A. worker in Poland. Later he took a medical course at the University of Manitoba, graduating with his M.D. degree.

* * *

HAMILTON, ONT.—All private and semi-private rooms at the General Hospital were filled on March 1st, as the total number in hospital reached the highest figure this year and for many months past, Dr. M. G. Browne, assistant superintendent, stated at that time.

Four hundred and fifty-eight patients were reported as being in hospital. There are 96 at the Mountain Hospital, where the capacity of the old wing is only 110. The capacity of the General Hospital is about 500.

* * *

KELOWNA, B.C.—The most successful annual statement ever turned in by the Kelowna Hospital Society was read at the annual meeting held recently, wherein it showed that the hospital had an operating profit of over $6000 for the year, before allowing for depreciation and interest on mortgage, and after these had been taken care of there was still a profit of $372.

KINGSTON, ONT.—In order to accommodate the large number of patients undergoing treatment, the General Hospital has opened up what is known as "Empire Four." This floor contains 22 beds.

When the new wing was added to the hospital, Empire 1, 2, 3 and 4 were closed until such times as there was a demand for their occupancy. One by one the floors have been reopened until now only Empire Three remains closed. This floor is now in the process of redecoration and painting and will be ready for use in the near future.

Two hundred and sixty-three patients were registered at the hospital on January 19th. With the medical staff, special nurses, hospital staff, and visitors staying over night, the average daily population of the hospital is about 630.

* * *

LACHINE, QUE.—A request by a delegation representing the Lachine General Hospital that the institution should benefit in future under the Public Charity Act at present in force in this province, has been granted at Quebec, and an order-in-council has been passed in this connection.

* * *

LONDON, ONT.—Recent findings of overcrowding at the Ontario Hospital here are expected to result in an early start on a large new patients' wing. Late last fall the foundation for the proposed new building was completed and Toronto reports indicate provision to complete the wing will be made in the province's 1935 estimates.

* * *

LONDON, ONT.—First aid stations along the highways between London and Windsor, and between London and Toronto are coming, according to C. E. Bernard, manager of the local motor club, but they may or may not be this year.

Mr. Bernard said that according to the plan, proposed some time ago, the cost would be divided, generally, three ways, with the Motor League bearing one-third, the Red Cross one third, and the St. John's Ambulance Corps the other third. The Motor League third would be divided further, among the motor clubs in the area affected.

Such a chain of first aid stations is now in effect between Toronto and the Quebec border, and it is costing about $3,000 annually.

* * *

MONCTON, N.B.—Rev. Sister Louise Gertrude, R.N., for the past seven years superintendent of nurses at Hotel Dieu Hospital here, has been transferred to a similar post at the Verdun General Hospital. She is being succeeded by Rev. Sister Anne de Paredes, R.N., who has arrived from Montreal to take over her new duties.

MONCTON, N.B.—Members of the executive committee of the Maritime Branch of the Catholic Hospitals Association convened in session at the Hotel Dieu Hospital here in February. Various matters of interest to the association and for the benefit of the hospitals were discussed.

Rev. Sister Kerr, R.N., of Campbellton, the president, presided, with Rev. Sister Kenny, R. N., of Chatham, secretary, also in attendance.

* * *

MONTREAL, QUE.—Doctor A. H. Pirie, director of the department of roentgenology of the Royal Victoria Hospital since 1911, has just tendered his resignation. Doctor E. C. Brooks has been appointed acting roentgenologist-in-chief.

* * *

MONTREAL, QUE.—Work on the Post Graduate Hospital of Montreal, which was postponed in 1932, will be started in May, it was announced in February by Dr. J. N. Chausse, medical director of the temporary Post Graduate Hospital Clinic on Park Lafontaine. This French-Canadian medical institution, which will cost $500,000, will be open to all races and creeds and will be built on the city land grant on Sherbrooke Street east, between Chambly and Valots streets.

* * *

MONTREAL, QUE.—Over six hundred guests attended the dance held in February at the Windsor Hotel under the distinguished patronage of Her Excellency the Countess of Bessborough, by the Alumnae' of the School for Graduate Nurses, McGill University, to assist in raising funds to maintain the school. Red and white, McGill colours, with palms and ferns formed the decorations in the ballroom, used for dancing, and in the Rose Room and dining-room where supper was served at midnight. Many ladies prominent in nursing and social circles attended.

* * *

MONTREAL, QUE.—"What You Don't Know Does Not Hurt" was the title of a lecture on anaesthesia delivered a few weeks ago by Dr. Harold Griffith, president of the Associated Anaesthetists of the United States and Canada, to the members of the Young Men's Club of the Homeopathic Hospital.

Dr. Griffith discussed the development of anaesthesia from the old-time methods of chloroform and ether, to modern anaesthetics, such as ethylene and chloropropane as inhalants, avertin, and various other anaesthetics given orally or by injection. The inhaled anaesthetic was still the most suitable for major surgery, he pointed out, because it was the most completely under control.

(Continued on next page)

News of Hospitals and Staffs

(Continued from preceding page)

MONTREAL, QUE.—During an informal visit to the Notre Dame Hospital recently, an inspection of the entire building was made by Lord Bessborough, accompanied by Lady Bessborough. With two aides-de-camp they arrived at the building at 3 p.m.

It was the second visit the Governor-General has made to the institution, having been there in 1931 upon the occasion of the opening of the new east wing. The visitors were received by Dr. B. T. Bourgeois, vice-president of the hospital, acting in the absence of Arthur Terroux, the president. In the tour of inspection that was subsequently made, Lady Bessborough was under the guidance of Mrs. de Lotbiniere Harwood.

Others present included Senator Raoul Dandurand, Hon. Athanase and Mrs. David, Mayor Camillien and Mrs. Houde.

* * *

ST. GEORGES DE BEAUCE, QUE.—The construction of a hospital costing approximately $75,000, the expenses to be defrayed by the municipality, is being considered by the town council.

* * *

SAULT STE. MARIE, ONT.—"The establishing of a base hospital at Mica Bay was a measure brought about through Dr. A. D. Roberts, M.L.A., to safeguard the 700 men now employed in the building of the Trans-Canada Highway," District Engineer R. A. McAllister, of the Department of Northern Development said recently, as he confirmed a statement made by Sanitary Inspector R. B. McCauley that a hospital would be built.

"The hospital was absolutely necessary,"," Mr. McAllister said, "in order that men injured at the camps, or who became ill, could receive adequate care under the supervision of a doctor. The hospital has 10 beds and is built of logs.

* * *

SUDBURY, ONT.—Arriving from Kapuskasing on February 17th, Rev. Sister St. Marie Eulalie has taken up her new duties as superior of St. Joseph's Hospital, a position left vacant by the recent death of Rev. Sister St. Aldegonde.

Her appointment to the post marks the second time Sister St. Marie Eulalie has succeeded the late Sister St. Aldegonde in her duties, since nearly 20 years ago the new hospital head succeeded Sister St. Aldegonde as principal of the Central separate school here.

* * *

TORONTO, ONT.—The reception room of the nurses' residence of the Toronto General Hospital was thronged when the graduate nurse staff, the social service department, the dietitians and the occupational therapeutists gathered to congratulate the superintendent, Miss Jean I. Gunn, on receiving the decoration of officer of the Order of the British Empire from His Majesty the King.

On behalf of the staff, Miss Purdy presented Miss Gunn with a handsome mahogany and walnut desk set and lamp.

TORONTO, ONT.—Hon. J. A. Faulkner, Ontario Minister of Health, on March 12th, announced the promotion of Dr. G. C. Brink from clinical physician to director of the division of tuberculosis prevention in the health department.

Dr. Faulkner said it would be Dr. Brink's duty to correlate the tuberculosis preventive work now being carried on by the Provincial department with that undertaken by sanatoria throughout the Province. He will also investigate tuberculosis cases that may find their way into ordinary hospitals.

* * *

TORONTO, ONT.—A reception was held at the Toronto General Hospital in February in honour of Charles H. Pannell on his retirement as Assistant House Manager of the hospital, and assisting head of the Private Patients' Pavilion. An informal program of music was presented by members of the Private Patients' Pavilion staff under the direction of Miss Nelly A. V. Brown. Presentations were made to Mr. and Mrs. Pannell by John Dewar, Household Manager of the hospital. Miss Joan Lunn of the Private Patients' Pavilion Housekeeping Department acted as hostess, assisted by Miss F. Atwood, Miss Lilian Taylor, Miss Hazel Gill, Mrs. John Porter and members of the hospital staff.

* * *

VANCOUVER, B.C.—A $3,000,000 building programme for the Vancouver General Hospital is being considered.

The plans call for the construction of about eight new buildings.

Most urgently required of these is a new nurses' home to cost $1,000,000.

An administration building, a new home for interns and a building for records and supplies, are also urgently needed.

* * *

VANCOUVER, B.C.—Intimation that construction of a new wing on St. Paul's Hospital is contemplated within the next year or two was conveyed to the City Council in a letter from the Sister Superior of the hospital.

The City Council was advised of the proposed new wing so it will be before that body when considering further extensions to the Vancouver General Hospital, the letter stated.

There are 395 beds in St. Paul's Hospital, with about 25 per cent vacancies at the present time.

* * *

VEGREVILLE, ALTA.—Remodelling and enlarging the X-Ray Department at the General Hospital is under way. A complete, new, shock-proof machine is being installed, thus assuring the public of a still better service. Undeterred by hard times, the Sisters are resolved to keep the General Hospital right in the forefront with the best of modern equipment.

* * *

VERNON, B.C.—The annual report of the Vernon Jubilee Hospital Association shows that for perhaps the

first time in its history, the hospital is free from debt. This is largely due to a reduction in the debt of $2600 made in the past year.

Hearty commendation was tendered by the meeting to the directors and particularly to Mrs. C. Hamilton-Watts, the president, for the painstaking care as a result of which the improved financial standing has been made possible.

* * *

VICTORIA, B.C.—A record for the number of patients in hospital was established at the Jubilee Hospital during the month of January.

During the month there was an average of 257 cases receiving treatment each day. The mark was the highest monthly average since the opening of the institution.

* * *

WINNIPEG, MAN.—Miss Margaret B. Allen, for the last nine years superintendent of nurses of the Children's Hospital of Winnipeg, has resigned. Miss Allan is a graduate of the Hospital for Sick Children of Toronto, and before going to Winnipeg held positions in several prominent hospitals in the United States. She was two and a half years with the child welfare department of the Saskatchewan Government. Miss Allan left for Bermuda early in March and on her return will visit New York, Boston, Hartford and other eastern U. S. cities.

* * *

WINNIPEG, MAN.—While 200 members and friends looked on, Mrs. A. J. Tuckwell, only surviving charter member of the board of the Convalescent hospital, let the mortgage on the building slip from her fingers into a fire prepared for it, on March 2nd, and a ceremony for which members had waited 18 years was complete.

The mortgage was issued in 1917 to finance the building of the present commodious Convalescent Hospital. It was signed by A. McTavish Campbell, Arthur Rogers, John Botterell and G. F. Stephens.

The Women's Hospital Society is the oldest women's association in Winnipeg.

* * *

YORKTON, SASK.—Miss Melvina Blais has been appointed technician in charge of the laboratory recently established at the Victoria Hospital, and has arrived from Regina to commence her new duties.

Miss Blais received her training under Dr. J. D. Prendergast, pathologist in charge of the laboratory at St. Boniface Hospital.

Prior to her appointment here Miss Blais had been relieving at the laboratory of the Grey Nuns' Hospital in Regina.

American Dietetic Association Meeting

The executive committee of the American Dietetic Association has voted to hold its 18th annual meeting at the Hotel Cleveland, Cleveland, Ohio, on October 28th to 31st, inclusive.

THE BUYERS' DIRECTORY

A directory of reputable manufacturers and distributors of Equipment and Supplies for Hospitals. Your perusal of these announcements, together with other advertisements in this issue, will be appreciated.

News of Hospitals and Staffs

Digby, N.S.

$2,000 each to the Digby General Hospital and St. Paul's Church at Marshall's Town, were bequests provided for in the will of Mrs. Maurice Goddard, who died at Newton, Mass., leaving an estate valued at $200,000. Mrs. Goddard was born in Digby and for many years was a summer visitor at Marshall's Town, where she owned a summer home. She was the widow of a prominent Boston attorney.

* * *

Glace Bay, N.S.

A new nurses' home, to cost approximately $60,000, will be constructed on the Glace Bay General Hospital premises this year. Construction will begin in the spring. This was the decision reached at a largely attended meeting of the hospital subscribers held on March 12th.

* * *

Goderich, Ont.

A delightful affair took place early in March at Alexandra hospital when the Maple Leaf Chapter, I.O.D.E., entertained at tea, to mark the opening of the new children's ward. This ward has been equipped by the Chapter in memory of their first regent, the late Mrs. Robert Jeffrey, of Toronto.

* * *

Kitchener, Ont.

Endorsation of a move on the part of the K-W Hospital Commission to proceed with plans for the erection of a new wing to the K-W Hospital was unanimously given by City Council in adopting a recommendation of the finance committee report.

Trust funds through appreciation of bond holdings now amount to nearly $44,000 and there is an additional $9,000 in a fund held by the local Shriners Club toward hospital building. The commission has a communication from the Shriners Club practically guaranteeing to meet any deficit between the available funds and the actual cost, it is stated.

THE BUYERS' DIRECTORY

A directory of reputable manufacturers and distributors of Equipment and Supplies for Hospitals. Your perusal of these announcements, together with other advertisements in this issue, will be appreciated.

Milden, Sask.

An "At Home' was held in the hospital recently to give a welcome to the new physician in charge, Doctor McNeill, and the new staff, with Miss McNulty as matron, and also to inaugurate the re-opening of the hospital which has been closed for several months.

Many people came from a distance in the country, giving evidence of their interest in the re-opening of the institution which has been of so great a benefit to the large district which it serves.

* * *

Montreal, Que.

Residents of Montreal interested in the progress of medical science may justly be proud of the achievements of their city for the Neurological Institute at McGill University stands second to none in Europe. This was the comment of Dr. Haddow M. Keith, formerly of the Mayo Clinic, Rochester, Minn., and now attached to the staff of the Montreal Neurological Institute, who has returned after six months intensive postgraduate research in some of the largest neurological clinics in Europe.

* * *

Ottawa, Ont.

Dr. D. M. Robertson, superintendent of the Ottawa Civic Hospital, and President of the Ontario Hospital Association, has been authorized by the hospital trustee board to attend the annual session of the International Hospital Association, which will convene in Rome the latter part of May. Dr. Robertson was granted two months holidays.

* * *

Penetanguishene, Ont.

The appointment of Mr. R. S. McLaughlin, of Midland, to the position of Bursar at the local Ontario Hospital has been made. Mr. McLaughlin will take over his new duties shortly. He will first go to the Mimico Hospital to study the system used in his new office. Mr. McLaughlin is an experienced bookkeeper and purchasing agent.

Index to Advertisers

Kings Jubilee Cancer Fund Appeal is Meeting Fine Response

The campaign to raise money for a national concer relief fund to commemorate the 25th anniversary of King George's accession to the throne is meeting with well deserved success. Response of the Canadian people is generously demonstrated by the flow of letters with contributions daily arriving at Government House in care of Her Excellency, the Countess of Bessborough, who has graciously undertaken to receive and acknowledge all contributions.

Over a coast-to-coast network of the Canadian radio broadcasting commission the Earl of Bessborough inaugurated the campaign on March 1st reminding the people that the Silver Jubilee of His Majesty can be permanently commemorated in no more fitting manner, and in no manner that would confer a greater benefit on the Canadian nation as a whole than by the creation of this permanent anti-cancer fund.

This fund is to be a fund for Canada, and Canada alone. It will be administered in perpetuity by seven Canadian trustees and its resources will be devoted to a continuous effort to reduce in Canada the high rate of mortality from cancer. When we realize that in 1933 almost 11,000 persons in Canada died of cancer, it is no wonder that this fund commends itself to the people, and it is hoped that the funds will make possible investigation and research to discover the cause and cure for this relentless foe. In the clinical application of a good deal of the research it is very likely that our hospitals will have the opportunity of co-operating extensively.

Limitation of Hours of Work Legislation Not to Affect Hospitals

Recently the Dominion Parliament passed legislation limiting the hours of work for employees in a number of industries, the Canadian firms will have a period of three months in which to adjust staffs before the federal eight-hour day and 48 hour week legislation becomes effective, after which time penalties will be assessed for infractions. Certain industries which would be impeded or penalized by the eight hour day are excluded from the act.

We have been informed by the Canadian Hospital Council that they have received information from the Department of Labour at Ottawa that this limitation of hours of labour will not affect hospitals.

At the present time, it is estimated that this act will affect about 35 per cent of Canadian workman and it is hoped that within a year it will be extended to include a greater number. The eight-hour day has proved its value in many industries, but it would certainly work a hardship if hospital employees were forced to come under its ruling.

S.S. "Normandie" to Have Modern Hospital and Health Service

The new super-liner "Normandie," due in New York on the first lap of her maiden voyage about June 3rd, will present as one of the startling features that mark the modern day of scientific advancement in shipbuilding and equipment, a general hospital without a dark or gloomy corner in it, and with every appliance and invention known to the world of medical and surgical care to-day, readily at hand.

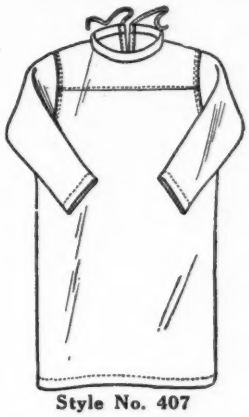
The medical care division will be in three parts, i.e., a hospital unit for passengers, another for members of the crew, and a medical and surgical clinic. There will also be a fully equipped apothecary shop on board with licensed pharmacists in charge.

The technical equipment of the new ship represents the latest and best in every detail that has thus far been devised. For example, the physiotherapy appliances consist of a short-wave diathermical machine with two 250-watt bulbs for use in all local and regional applications. The outstanding medical value here is the effect of heat in atonic cases, as for example in case of indigestion, peripheral circulation, neuralgia, rheumatism and glandular trouble. The well-known actinic shower invented by Dr. Dausset of the Hotel-Dieu in Paris, with its movable lamplamp operating on rails, sufficiently powerful to develop 20 amperes, regarded to-day as the "last word" in artificial sun-baths, will be available to passengers.

The radiology room on the new super-liner, will be equipped with a Massiot machine, radiostat at 34, generator PV 4, which has made the use of radioscopy and radiography readily possible.

Designed for Comfort and Efficiency

Sales tax is NOT included in quotations, as same does not apply when garments are shipped to approved Hospitals under their purchase orders bearing the required Sales Tax exemption certificate.



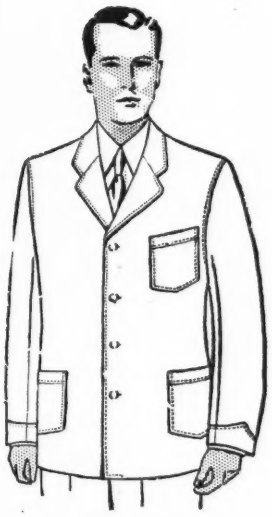
Style No. 407

PATIENT'S BED GOWN

Standard length, 40 inches, closes down back with tie tapes, or linen buttons, if preferred, reinforced with yoke both back and front.

Material Number	Description	Per doz.
97	Unbleached Sheeting	$ 6.75
99	Best Quality Unbleached Sheeting	9.00
58	High Quality Bleached Sheeting	9.50
56	Bleached Marble Head	10.50

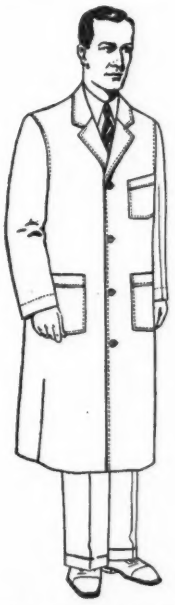
Bed Gowns, freight prepaid to your address on lots of 12 dozen or more or an assortment of "Hospital Apparel" items amounting to $100.00 or more.



Style No. 113

HOUSE DOCTOR'S COAT
Style No. 113-79

Made of bleached drill, this coat is neat and serviceable. It has the lay down collar, three pockets, detachable buttons and pointed cuff on sleeve. Price for the coat, **$24.00** per dozen. Pants to match, **$24.00** per dozen.



Style No. 175

HOUSE DOCTOR'S SHIRT

Made of the best quality bleached shirting, our No. 65. Price **$15.00** per doz.

SURGEON'S COAT—Style No. 215

A popular coat for making "rounds," also for clinics and laboratory use. Made of best quality bleached duck. Has lapel collar, three pockets and side openings to permit access to inner pockets when coat is buttoned, pointed cuff on sleeves, detachable buttons. Length about 46 inches. Price **$27.00** per doz.

Made in Canada by

CORBETT-COWLEY
Limited

690 King St. W., TORONTO **637 Craig St. W., MONTREAL**

32

Our exclusive winding method keeps

"ZO" Adhesive Plaster

uniform from end to end

● THE J. & J. PROTECTIVE HOLDER.

● "Z O" Adhsive Plaster spools are wound under uniform tension, which makes them less difficult to unroll. The last inch is as easy to detach, and as usable, as the first piece off the roll. Much time and money have been spent in the J. & J. laboratories on the present formula of "Z O". The old theory that the best adhesive was the one most difficult to unroll has been exploded. The adhesive mass of "Z O" is uniform in consistency, and remains uniform until used. It reaches its maximum adhesive strength at body temperature. Supplied in hospital spools, 12" x 10 yds., cut in assorted widths. The Protective Holder keeps "Z O" always neat and clean.

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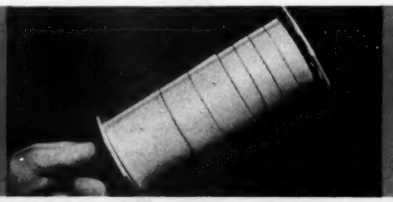
MONTREAL CANADA

● "Z O" HOSPITAL ROLLS. 12" x 5 yds., uncut. Meets the need of adhesive plaster to cover wide areas. Securely packed in neat, metal-end cylinder. Also available in Drybak.



● "Z O" HAND RACK. Very handy for use on dressing tables and operating room carts. Made of aluminum. Holds several spools of various widths. Won't roll off table.

● K-Y LUBRICATING JELLY. The sterile lubricant for every penetrative purpose. K-Y is consistent, lucid, greaseless, instantly soluble in water. Prices now substantially lower.